Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PARUL R SHAH DO
P O BOX 121589
ARLINGTON TX 76012

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-2292-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These services were requested and prescribed by the Division. The above referenced designated doctor performed the MMI examination and assigned the IR, but he did not perform the range of motion, strength, or sensory testing of the musculoskeletal body area(s), that means he should bill using the appropriate MMI CPT cod 99456 with the component modifier -26. Reimbursement for the examining doctor is 80% of the MAR. The physical therapist and/or health care provider other than the examining doctor that performs the range of motion, strength, or sensory testing of the musculoskeletal body, the physical therapist and/or health care provider will bill with the component – TC. In this instance, reimbursement to the physical therapist and/or health care provider is 20% of the MAR. The bills from the two parties must be coordinated and billed appropriately and should be billed at the same time for the correct reimbursement."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not include a position summary with their response to the dispute."

Response Submitted by: Gallagher Bassett, 6750 West Loop South #300, Bellaire, TX 77401

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 16, 2011	CPT Code 99456-W5-TC	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 26, 2011
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT

   Explanation of benefits dated December 23, 2011
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT

   Explanation of benefits dated January 27, 2012
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT

Issues

1. Were the services in dispute appropriately billed?
2. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
3. Is the requestor entitled to additional reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The requestor billed the amount of $800.00 for CPT CODE 99456-W5-26 for the professional component of Maximum Medical Improvement/Impairment Rating (MMI/IR) as a designated doctor. The provider also billed the amount of $800.00 for CPT code 99456-W5-TC for the technical component of MMI/IR examination. Documentation supports that the MMI determination is payable at $350.00. For the IR, methods of calculating IR and the number of body areas determine reimbursement. Documentation supports that MMI was assigned and two body areas were rated. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for an IR using Diagnosis Related Estimates (DRE) method on the cervical spine is $150.00. Per Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a), the MAR for a 1st musculoskeletal area IR using Range of Motion (ROM) on the left shoulder (upper extremities) is $300.00. Texas Administrative Code §134.204 states in part (j)(4)(C) (iv) and (v):

   > (iv) If, in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment), the examining doctor performs the MMI examination and assigns the IR, but does not perform the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the examining doctor shall bill using the appropriate MMI CPT code with CPT modifier "26". Reimbursement shall be 80 percent of the total MAR.
   >
   > (v) If a HCP, other than the examining doctor, performs the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the HCP shall bill using the appropriate MMI CPT code with modifier "TC." In accordance with §130.1 of this title, the HCP must be certified. Reimbursement shall be 20 percent of the total MAR.

2. Review of the submitted documentation and the Division rules above show that the combined MAR for the MMI/IR exam is $800.00.
3. The respondent has previously reimbursed the amount of $580.00 for CPT code 99456-W5-26 and $70.00 for the disputed CPT code 99456-W5-TC which totals $650.00. An additional amount of $150.00 is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 29, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.